FY07 HEALTH PLAN DESCRIPTION FORM – PPO				
	PPO - 1500		PPO - 3300	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Important Note: This form is not a contract. It is only a summary. The contents of this form are subject to the provisions of the Plan, which contains all terms, covenants and conditions of coverage. Your Plan may exclude coverage for certain treatments, diagnoses or services not noted below. The benefits shown in this summary may only be available if required Plan procedures are followed (e.g. Plans may require Pre-Treatment Authorization or use of specified providers or facilities). Consult the actual Summary Plan Description to determine the exact terms and conditions of coverage. Coinsurance % reflects the amount the Plan will pay.				
Part A: Type of Coverage				
1. Type of Plan	Preferred Provider Organization			
2. Out-of-Network Care Covered?[1]	Yes, but patient pays more for out-of-network care.			
3. Areas of Colorado where Plan is Available	Plan is available nationally.			
Part B: Summary of Benefits				
4. Plan Year Deductible **a) Individual** **b) Family**	 $1,500 $3,000 The in-network deductible may not be used to satisfy the out-of-network deductible.	 $3,000 $6,000 The out-of-network deductible may not be used to satisfy the in-network deductible.	 $3,300 $6,600 The in-network deductible may not be used to satisfy the out-of-network deductible.	 $6,600 $13,200 The out-of-network deductible may not be used to satisfy the in-network deductible.
5. Plan Year[2] **Out-of-Pocket maximum (includes deductible, if any)** **a) Individual** **b) Family**	 $3,000 $6,000 The in-network out-of-pocket maximum may not be used to satisfy the out-of-network out-of-pocket maximum.	 $6,000 $12,000 The out-of-network out-of-pocket maximum may not be used to satisfy the in-network out-of-pocket maximum.	 $5,000 $10,000 The in-network out-of-pocket maximum may not be used to satisfy the out-of-network out-of-pocket maximum.	 $10,000 $20,000 The out-of-network out-of-pocket maximum may not be used to satisfy the in-network out-of-pocket maximum.
6. Lifetime Maximum	No lifetime maximum with 2 exceptions: a) surgical treatment of morbid obesity, if Medically Necessary, is covered up to a lifetime maximum of $7,500 including complications; b) Substance Abuse 60-day inpatient and 60-visit outpatient lifetime maximum.			
7. Covered Providers	Great-West Healthcare Preferred Provider Network, Pharmacy Services provided by Express Scripts® and Vision Services provided by Avesis®. Both are by arrangement with Great-West Healthcare.	All providers licensed or certified to provide covered benefits.	Great-West Healthcare Preferred Provider Network, Pharmacy Services provided by Express Scripts® and Vision Services provided by Avesis®. Both are by arrangement with Great-West Healthcare.	All providers licensed or certified to provide covered benefits.
8. Medical Professional Services	80% after deductible	60% after deductible	70% after deductible	50% after deductible
9. Office Visits	80% after deductible	60% after deductible	70% after deductible	50% after deductible
10. Scheduled Preventive Care **a) Children** **b) Adults**	 80% not subject to deductible 80% not subject to deductible	 60% not subject to deductible 60% not subject to deductible	 70% not subject to deductible 70% not subject to deductible	 50% not subject to deductible 50% not subject to deductible

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11. Maternity				
a) Prenatal care	80% after deductible	60% after deductible	70% after deductible	50% after deductible
b) Delivery	80% after deductible	60% after deductible	70% after deductible	50% after deductible
c) Delivery professional services	80% after deductible	60% after deductible	70% after deductible	50% after deductible
12. Prescription Drugs	a) & b) & c) subject to $100 per member Rx deductible before copays apply.		a) & b) & c) subject to $100 per member Rx deductible before copays apply.	
a) Retail Copays **- Generic** **- Preferred** **- Non-Preferred**	$10 $25 $50 (30-day supply)	Not Covered	$10 $25 $50 (30-day supply)	Not Covered
b) Mail Order Copays **- Generic** **- Preferred** **- Non-Preferred**	$20 $50 $100 (90-day supply)	Not Covered	$20 $50 $100 (90-day supply)	Not Covered
c) Self-admin. Injectables disp. thru pharmacy	**Plan pays 70%. Member share not to exceed $250 per 34-day supply or $500 per 90-day supply.**	Not Covered	**Plan pays 70%. Member share not to exceed $250 per 34-day supply or $500 per 90-day supply.**	Not Covered
d) Injectables admin. in office or OP facility	**70% after deductible (Plan Year deductible – see #4 above.)**	Not Covered	**70% after deductible (Plan Year deductible – see #4 above.)**	Not Covered
The Prescription Drug Program has been designed to encourage the use of generic medications. If a generic drug is available, but the preferred drug is dispensed (whether by your request or upon a physician specifying "Dispense As Written"), you are required to pay the applicable preferred copayment PLUS the difference in cost between the generic and preferred drug. The Food and Drug Administration (FDA) requires generic drugs to have the same quality, strength, purity and stability as preferred drugs.				
13. Inpatient Hospital	80% after deductible	60% after deductible	70% after deductible	50% after deductible
14. Outpatient / Ambulatory Surgery	80% after deductible	60% after deductible	70% after deductible	50% after deductible
15. Other services				
a) Laboratory	80% after deductible	60% after deductible	70% after deductible	50% after deductible
b) X-ray	80% after deductible	60% after deductible	70% after deductible	50% after deductible
c) MRI / PET / CAT scans	80% after deductible	60% after deductible	70% after deductible	50% after deductible
b) & c) subject to Pre-Treatment Authorization				
16. Emergency Care[3]	80% after deductible	60% after deductible	70% after deductible	50% after deductible

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17. Ambulance				
a) Ground	80% after in-network deductible, maximum benefit $1,000 per trip.		70% after in-network deductible, maximum benefit $1,000 per trip.	
b) Air	80% after in-network deductible, maximum benefit $10,000 per trip.		70% after in-network deductible, maximum benefit $10,000 per trip.	
18. Urgent Care[3]	80% after deductible	60% after deductible	70% after deductible	50% after deductible
19. Biologically Based Mental Health[4] **Care**	Covered same as any other Illness	Covered same as any other Illness	Covered same as any other Illness	Covered same as any other Illness
20. Other Mental Health Care	Maximum 45 full/90 partial days for inpatient services and 30 visits for outpatient services per Plan Year. Number of days and visits applies to both in and out-of-network; combined with Substance Abuse.			
a) Inpatient care	80% after deductible	60% after deductible	70% after deductible	50% after deductible
b) Outpatient care	80% after deductible	60% after deductible	70% after deductible	50% after deductible
21. Substance Abuse	Maximum 45 full/90 partial days for inpatient and 30 visits for outpatient per Plan Year. Number of days and visits applies to both in and out-of-network; combined with other Mental Health. Lifetime maximum 60 full days for inpatient and 60 visits for outpatient. Other Mental Health is not subject to the 60-day or 60-visit lifetime limit, but inpatient days and outpatient visits for such services do apply to and reduce the 60-day or 60-visit lifetime limit for Substance Abuse.			
a) Inpatient rehab.	80% after deductible	60% after deductible	70% after deductible	50% after deductible
b) Outpatient	80% after deductible	60% after deductible	70% after deductible	50% after deductible
22. Physical, Occupational & Speech Therapy				
a) Inpatient	80% after deductible	60% after deductible	70% after deductible	50% after deductible
b) Outpatient	80% after deductible, maximum 20 visits per Plan Year for each therapy. The number of visits applies to both in and out-of-network.	60% after deductible, maximum 20 visits per Plan Year for each therapy. The number of visits applies to both in and out-of-network.	70% after deductible, maximum 20 visits per Plan Year for each therapy. The number of visits applies to both in and out-of-network.	50% after deductible, maximum 20 visits per Plan Year for each therapy. The number of visits applies to both in and out-of-network.
23. Durable Medical Equipment				
a) Inpatient	80% after deductible	60% after deductible	70% after deductible	50% after deductible
b) Outpatient	80% after deductible, maximum of $3,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to $3,000 max, but expenses for such devices are applied to and reduce the $3,000 max.)	60% after deductible, maximum of $3,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to $3,000 max, but expenses for such devices are applied to and reduce the $3,000 max.)	70% after deductible, maximum of $3,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to $3,000 max, but expenses for such devices are applied to and reduce the $3,000 max.)	50% after deductible, maximum of $3,000 per Plan Year for in and out-of-network expenses combined. (Prosthetic devices are not subject to $3,000 max, but expenses for such devices are applied to and reduce the $3,000 max.)
24. Medical Supplies	80% after deductible	60% after deductible	70% after deductible	50% after deductible
25. Oxygen				
a) Inpatient	Included in Hospital	Included in Hospital	Included in Hospital	Included in Hospital
b) Outpatient	80% after deductible	60% after deductible	70% after deductible	50% after deductible
26. Transplants	80% after deductible	Not Applicable (Transplants must be in-network.)	80% after deductible	Not Applicable (Transplants must be in-network.)

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27. Home Health Care ***subject to Pre-Treatment Authorization***	80% after deductible 60 visits per Plan Year. Maximum includes in and out-of-network visits.	60% after deductible 60 visits per Plan Year. Maximum includes in and out-of-network visits.	70% after deductible 60 visits per Plan Year. Maximum includes in and out-of-network visits.	50% after deductible 60 visits per Plan Year. Maximum includes in and out-of-network visits.
28. Hospice				
a) Inpatient	80% after deductible 30 days per PlanYyear. Number of days applies to both in and out-of-network.	60% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.	70% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.	50% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.
b) Outpatient	80% after deductible 91 days per Plan Year. Number of days applies to both in and out-of-network.	60% after deductible 91 days per Plan Year. Number of days applies to both in and out-of-network.	70% after deductible 91 days per Plan Year. Number of days applies to both in and out-of-network.	50% after deductible 91 days per Plan Year. Number of days applies to both in and out-of-network.
29. Skilled Nursing Facility Care	80% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.	60% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.	70% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.	50% after deductible 30 days per Plan Year. Number of days applies to both in and out-of-network.
30. Dental Care	Not covered	Not covered	Not covered	Not covered
31. Vision Care	After $50 copay, Plan pays 100%. One exam every Plan Year. No benefit for hardware, but a discount is available through Avesis® network.	After $50 copay, Plan pays 100% up to $35. One exam every Plan Year. No benefit for hardware.	After $50 copay, Plan pays 100%. One exam every Plan Year. No benefit for hardware, but a discount is available through Avesis® network.	After $50 copay, Plan pays 100% up to $35. One exam every Plan Year. No benefit for hardware.
32. Manual Manipulation – Chiropractic Care and Acupuncture	80% after deductible, maximum benefit $750 per Plan Year per benefit. Maximum applies to both in and out-of-network visits.	60% after deductible, maximum benefit $750 per Plan Year per benefit. Maximum applies to both in and out-of-network visits.	70% after deductible, maximum benefit $750 per Plan Year per benefit. Maximum applies to both in and out-of-network visits.	50% after deductible, maximum benefit $750 per Plan Year per benefit. Maximum applies to both in and out-of-network visits.
33. Significant Additional Covered Services				
a) Hearing Aids	100% after deductible, limited to $500 every 3 years. Maximum applies to both in and out-of-network.	100% after deductible, limited to $500 every 3 years. Maximum applies to both in and out-of-network.	100% after deductible, limited to $500 every 3 years. Maximum applies to both in and out-of-network.	100% after deductible, limited to $500 every 3 years. Maximum applies to both in and out-of-network.
b) Infertility	80% after deductible, maximum benefit $2,500 per Plan Year. Limit applies to both in and out-of-network.	60% after deductible, maximum benefit $2,500 per Plan Year. Limit applies to both in and out-of-network.	70% after deductible, maximum benefit $2,500 per Plan Year. Limit applies to both in and out-of-network.	50% after deductible, maximum benefit $2,500 per Plan Year. Limit applies to both in and out-of-network.

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Part C: Limitations and Exclusions				
34. Period During which Pre-Existing Conditions are not Covered	Not applicable. Plan does not impose limitation periods for pre-existing conditions.			
35. What Treatments & Conditions are excluded Under this Policy?	See Summary Plan Description for list of exclusions.			
Part D: Using the Plan				
36. Does the enrollee have to obtain a referral for specialty care in most or all cases?	No	No	No	No
37. Is Pre-Treatment Authorization required for surgical procedures and hospital care (except in an emergency)?	Yes. See Summary Plan Description for list of procedures.	Yes. See Summary Plan Description for list of procedures.	Yes. See Summary Plan Description for list of procedures.	Yes. See Summary Plan Description for list of procedures.
38. If the provider charges more for a covered service than the Plan normally pays, does the enrollee have to pay the difference?	No	Yes	No	Yes
39. What is the main customer service number?	1-888-ST8-OFCO (1-888-788-6326)			
40. Whom do I write/call if I have a complaint or want to file a grievance?	Call the Great-West Customer Service Department at (1-888-788-6326)			
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Submit Appeals form to: **Great-West Healthcare** Attention Appeals/Grievance 8525 E. Orchard Road, 4T3 Greenwood Village, Colorado 80111			
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy	Policy Number: 179528 Self-funded large group.			

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43. Does the Plan have a binding arbitration clause?	No			
44. What is the cost of this Plan? **a) Employee Only** **b) Employee + Child(ren)** **c) Employee + Spouse** **d) Family**	Rates are available on the Benefits website www.colorado.gov/dpa/dhr/benefits.			

[1]Network refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your Plan may require you to use in order for you to get any coverage at all under the Plan, or that the Plan may encourage you to use because it pays more of your bill if you use network providers (i.e. go in-network) than if you don't (i.e. go out-of-network).

[2]Out-of-pocket maximum. The maximum amount you will have to pay for allowable covered expenses under a health Plan, which may or may not include the deductible or copay, depending on the contract for that Plan.

[3]Emergency Care means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Urgent care means situations that are not life threatening but require prompt medical attention to prevent serious deterioration in a member's health.

[4]Biologically Based Mental Health means: autism, schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.